

CMS K0011 Clarification: Bad Policy, Worse Implementation

IHATE TO START WITH A DISCLAIMER, BUT I AM not a Medicare beneficiary yet. So I talked with my peers who rely on Medicare for primary health insurance coverage. Their criticisms frighten me. Consumers of personal mobility systems involving code K0011 feel betrayed by providers and confused by Medicare bureaucracy. **BY DAVID T. WILLIAMS**

Neither the intent nor the rationale behind this "clarification" has been effectively communicated to consumers by CMS. At the same time, too many rehab technology companies (RTCs) are doing a poor job explaining major changes in the policies and procedures they must follow to be paid for rehab goods and services and to avoid post-payment audits. Consumers also feel Medicare is accusing them of fraud. Two examples:

One consumer has used a mobility system that includes a power chair base for 27 years due to quadriplegia. His current base is more than eight years old and beyond repair. It needs to be replaced, the fourth time for this beneficiary. However, due to new procedures necessary under the clarification, his RTC directed him to see his physician so Medicare could "justify" his replacement base.

The physician, in an effort to support his "best medical judgment," referred him to an OT for a seating evaluation. Once that was done, the RTC — a company he'd dealt with for 25 years — informed him they would be submitting an Advanced Determination of Medicare Coverage (ADMC) to be certain they would be reimbursed for a new base that was obviously

medically necessary. On three previous occasions a new base was provided and paid for by Medicare with the only documentation being a pad prescription from his physician that read, "New power wheelchair."

Another consumer was forced to switch from a manual to a motorized system because of progressive pain and weakness attributable to post-polio syndrome. His rehab provider, based on an evaluation done in a seating clinic, fit him with an appropriate mobility system and submitted the claim to Medicare. The consumer was later contacted by an "investigator" from the fraud unit of the DMERC. The investigator asked about the consumer's ability to ambulate independently. The consumer, being honest, said he is able to stand with assistance when getting dressed and makes independent transfers from his chair to the bed or commode. A week later the claim was denied due to "the beneficiary's ability to ambulate independently." In this case, the consumer's major life changes were complicated by a system that accused him of fraud for following his doctor's orders!

CMS is trying to reduce fraud and abuse. That is laudable. However, it has gone about it in a

way that wreaks havoc on the industry and the lives of the people it serves. There is a better way.

Medicare beneficiaries and K0011 providers should be given CMS-generated, printed materials that outline steps that must be followed for Medicare to cover a motorized personal mobility system. This would result in uniform documentation for all claims. If an OT/PT evaluation is going to be required, CMS must develop and distribute a standardized evaluation form. The industry's ability to comply with Medicare regulations is constantly obstructed by CMS' refusal to provide standardized procedures and forms. This has resulted in inconsistency and confusion for consumers and providers alike.

Consumers need to know exactly what is expected of them and their provider from the get-go. Accurate information and standardized forms will go further to reduce fraud and abuse than the obtuse language of the recent "clarification" of payment policy and coverage guidelines. It's time to call a spade a spade.

The entity most responsible for the increase in K0011 fraud is CMS itself. Because CMS lacks the guts or the ability to clearly express its policies and procedures in language that is understandable to consumers and providers alike, it has created an environment that facilitates the fraud and abuse it is now attempting to stop. ●

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